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ABSTRACT

Health insurance benefit programs in Texas community college districts fall into three groups. Comprising 25% of the districts, districts fall into three groups. Comprising 25% of the districts, the "help me now" group has experienced heavy group health insurance benefit utilization over the past few years and is unable to purchase required coverage at rates even close to state funding. The second group, the "we're okay for now" group, comprises about 50% of community college districts and purchases coverage at or near the state funding level. The final group, the "what's the problem" group, comprises about 25% of community college districts and purchases group health insurance at a price well below the state funding level. This final group may be unprepared for the runaway health insurance premiums which have already struck the other districts. There is evidence that group health insurance premiums will double every 3 years. The components of this increase in health care costs are medical inflation, cost shifting, increased utilization, catastrophic cases, technological advances, and malpractice. Factors more specific to community colleges include minimum benefit standards, adverse risk selection, an aging population, and health maintenance organizations draining the healthier risk population pool. The formation of a statewide consortium of community college districts managed by a common benefit consulting firm to provide employee health benefits would result in: lower administrative costs; lower pooling charges; rate stability; reduced staff costs; increased carrier interest; political influence; and greater autonomy and self-determination. Presentation overheads, and guidelines for implementing a consortia are included. (JMC)

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STATEWIDE COMMUNITY COLLEGE

EMPLOYEE BENEFIT CONSORTIUM

JERRY T. GUY

September 11, 1989

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The following is the text and exhibits of a presentation made by Jerry T. Guy of Guy Benefits Consulting to a Group of College Presidents in Austin, Texas on September 11, 1989.

INTRODUCTION

WE ARE HONORED TO BE A PART OF SUCH AN IMPORTANT PROJECT. THE CONFIDENCE SHOWN IN US BY THE SELECTION COMMITTEE PLACES UPON OUR ORGANIZATION AN AWESOME BURDEN OF RESPONSIBILITY. FOR YOU SEE, IT IS LEFT TO ME TO STAND BEFORE YOU, AND TO PROVIDE YOU WITH THE INFORMATION YOU WILL NEED TO MAKE THE RIGHT DECISION REGARDING THIS FINAL OPPORTUNITY LEFT TO YOU TO MAINTAIN SOME DEGREE OF AUTONOMY AND SELF DETERMINATION IN THE MANAGEMENT OF YOUR DISTRICT'S EMPLOYEE BENEFIT PROGRAM.

THREE CATEGORIES OF DISTRICTS IN THE AUDIENCE

AS I ADDRESS THIS AUDIENCE I AM AWARE THAT IT IS DIVIDED INTO THREE COMPONENTS. THE FIRST GROUP, WHICH IS COMPRISED OF APPROXIMATELY 25% OF THE DISTRICTS, FALLS INTO THE CATEGORY I WILL CALL THE **"HELP ME NOW'S!"**. THESE DISTRICTS HAVE EXPERIENCE HEAVY GROUP HEALTH INSURANCE BENEFIT UTILIZATION OVER THE PAST FEW YEARS, AND ARE NOW UNABLE TO PURCHASE REQUIRED COVERAGES FOR RATES THAT ARE EVEN CLOSE TO THE LEVEL OF STATE FUNDING. FOR THESE DISTRICTS, CARRIER INTEREST IS AT AN ALL TIME LOW. THESE DISTRICTS ARE FORCED TO PROVIDE SUBSTANTIAL PLAN FUNDING FROM THE LOCAL DISTRICT BUDGET, AND MUST REQUIRE EMPLOYEES TO PAY EXCESSIVE RATES TO COVER DEPENDENTS. FOR THESE DISTRICTS, THE DECISION TO JOIN A VOLUNTARY CONSORTIUM IS AN EASY ONE.

THE SECOND SEGMENT OF DISTRICTS IN ATTENDANCE TODAY I WILL REFER TO AS THE **"WE'RE OKAY FOR NOW'S"**. COMPRISING ABOUT 50% OF THE TOTAL, THESE DISTRICTS ARE ABLE TO PURCHASE REQUIRED COVERAGES AT, OR NEAR, THE STATE FUNDING LEVEL. HOWEVER, THESE DISTRICTS ARE ALSO ABLE TO SEE THE DIRECTION THIS WHOLE AREA OF GROUP HEALTH INSURANCE IS HEADING, AND ARE CONCERNED AS TO THEIR ABILITY TO REMAIN "OKAY FOR NOW". THESE DISTRICTS UNDERSTAND THAT THEY ARE PERHAPS ONE MORE RENEWAL AWAY FROM JOINING THE "HELP ME NOW'S!". FOR THESE DISTRICTS, THE DECISION TO JOIN A VOLUNTARY CONSORTIUM EFFORT IS NOT TOO DIFFICULT BECAUSE THE POTENTIAL SHORT-TERM COST IS WELL WORTH THE LONG TERM GAIN.

THE THIRD GROUP REPRESENTED HERE TODAY I WILL REFER TO AS THE **"WHAT'S THE PROBLEM?"** GROUP. THESE DISTRICTS, COMPRISING ROUGHLY 25% OF THE TOTAL, ARE PURCHASING GROUP HEALTH INSURANCE AT A PRICE WELL BELOW THE STATE FUNDING LEVEL. FOR THEM, THE DECISION TO JOIN A VOLUNTARY CONSORTIUM EFFORT WILL BE MOST DIFFICULT. FRANKLY, I AM GOING TO DIRECT MOST OF MY COMMENTS TO THIS GROUP BECAUSE THEY HAVE NOT BEEN FORCED BY CIRCUMSTANCE TO BECOME FULLY AWARE OF THE PROBLEMS FACING DISTRICTS IN THE AREA OF GROUP HEALTH INSURANCE COSTS.

PERHAPS THESE DISTRICTS ARE COMPRISED OF SOME OF THE NEWER DISTRICTS WITH A LOW AVERAGE AGE, FEW RETIREES, AND OTHER FACTORS THAT TEND TO HAVE A POSITIVE IMPACT ON PRICING OF GROUP HEALTH INSURANCE. PERHAPS THESE DISTRICTS HAVE ENJOYED EXCELLENT HEALTH AMONG THEIR EMPLOYEE/DEPENDENT CENSUS.

FOR WHATEVER REASON, THESE DISTRICTS HAVE REMAINED UNTOUCHED BY THE "RUN-AWAY" HEALTH CARE COSTS PLAGUING MOST OF THEIR PEERS. I WOULD LIKE TO PAINT A MENTAL PICTURE OF HOW I CHARACTERIZE THESE DISTRICTS.

THE LITTLE DUTCH BOY METAPHOR

THIS SITUATION CALLS TO MIND A MENTAL IMAGE OF THE FAMOUS STORY ABOUT THE LITTLE DUTCH BOY. THESE DISTRICTS HAVE BUILT A DIKE TO PROTECT THEM AGAINST THE RAGING SEA OF RISING HEALTH CARE COSTS. THE DIKE IS BUILT OF YOUTHFULNESS, GOOD HEALTH, AND PERHAPS SIMPLY GOOD FORTUNE. ALL THE PROPER STEPS HAVE BEEN TAKEN TO INSURE THAT THE DIKE WILL HOLD BACK THE RISING TIDE OF HEALTH CARE COSTS. PRE-CERTIFICATION OF HOSPITAL ADMISSIONS, PREFERRED PROVIDER ORGANIZATION DISCOUNTS, BENEFIT DESIGNS THAT ENCOURAGE OUTPATIENT CARE ARE ALL IN PLACE AS A STRATEGY TO REMAIN "HIGH AND DRY" WHILE OTHERS ARE DROWNING. OH, THERE IS A CRACK THAT IS BEGINNING TO LEAK, BUT THE DISTRICT'S BENEFITS MANAGER HAS PLUGGED THE LEAK BY STICKING HIS FINGER IN THE CRACK. ALL SEEMS TO BE WELL. THERE APPEARS TO BE NO IMMINENT DANGER. A STRONG SENSE OF STABILITY AND SECURITY IS PRESENT.

ALONG COMES A WISE OLD SEAMAN WHO KNOWS THE WAYS OF THE SEA, AND ITS FORESHADOWING WARNINGS OF IMPENDING DANGER. HE TRIES TO CONVINCE THOSE LIVING BEHIND THE SAFETY OF THE DIKE THAT DOOM LIES JUST OVER THE HORIZON. BUT WILL THEY HEED THE OLD MAN'S WARNING? FOR JUST OVER THE HORIZON, ON A DIRECT BEARING FOR THE DIKE IS A HUGE TIDAL WAVE THAT IS SO HIGH, AND SO POWERFUL THAT NEITHER THE DIKE, NOR THE LITTLE DUTCH BOY CAN TURN IT BACK. IT WILL SURELY ENGULF THE CITY RESTING SO SECURELY BEHIND THE DIKE. THE ONLY HOPE FOR THE CITY IS FOR IT TO JOIN WITH ITS NEIGHBORS TO CONSTRUCT A DIKE HIGH ENOUGH AND STRONG ENOUGH TO WITHSTAND THE FULL FURY OF THE TIDAL WAVE.

THE QUESTION IS, "WILL THE LEADERSHIP IN THE CITY HEED THE OLD MAN'S WARNING IN TIME TO AVOID CERTAIN DESTRUCTION?" OR WILL HE BE WRITTEN OFF AS A MAD MAN. THERE IS STILL ENOUGH TIME TO AVOID DISASTER. BUT THE DECISION MUST BE MADE NOW!

IN A VERY REAL SENSE, I AM CAST IN THE ROLE OF THE OLD SEAMAN. THE WORDS I SPEAK TODAY, IF HEEDED, CAN AVERT DISASTER. IF NOT, NO DISTRICT WILL ESCAPE THE CERTAIN CONSEQUENCES OF ITS FAILURE TO RESPOND.

IF YOU HAVE FOLLOWED ALONG WITH THE METAPHOR YOU MUST BE THINKING, "WHAT PROOF IS THERE THAT WHAT HE'S SAYING IS TRUE?" YOU ARE MEN AND WOMEN OF LEARNING. YOU SHOULD REQUIRE PROOF OF ANY HYPOTHESIS. I WILL PROVIDE THOSE ELEMENTS OF PROOF THAT WILL GIVE YOU THE INFORMATION YOU REQUIRE.

GENERAL FACTORS IMPACTING HEALTH CARE COSTS IN THE 1990'S

A RECENT STUDY CONDUCTED BY HEWITT ASSOCIATES INDICATES THAT THE AVERAGE GROUP HEALTH INSURANCE PREMIUM INCREASE IN 1989 WAS 30%. IF THIS TREND CONTINUES, HEALTH INSURANCE PREMIUMS WILL DOUBLE EVERY THREE YEARS. IT IS DIFFICULT TO IMAGINE THAT THE STATE'S BENEFIT FUNDING APPROPRIATION WILL KEEP PACE WITH PREMIUM INCREASES. IT CERTAINLY HASN'T IN THE PAST.

TREND FACTORS, THE INDEX USED BY INSURANCE COMPANIES TO PROJECT NEXT YEAR'S CLAIMS BASED ON THE CURRENT YEAR'S UTILIZATION LEVELS IS PROJECTED IN THE SAME HEWITT ASSOCIATES STUDY TO BE 21.5% FOR 1989 AND 1990. SIMPLY STATED, CARRIERS EXPECT THAT IF THE SAME CLAIMS WERE TO EXACTLY REPLICATE NEXT YEAR, IT WOULD REQUIRE 21.5% MORE DOLLARS TO FUND THESE SAME CLAIMS.

WHAT ARE THE COMPONENTS OF THIS OVERALL INCREASE IN HEALTH CARE COSTS? PERHAPS IF WE UNDERSTAND THE CAUSES, WE CAN TAKE PREVENTIVE ACTION.

	1988	1989
MEDICAL INFLATION - THE MEDICAL COMPONENT OF THE CONSUMER PRICE INDEX	35.5%	32.8%
COST SHIFTING - SHIFTING OF COSTS TO INDEMNITY PLANS DUE TO MEDICARE, MEDICAID, CHARITY CARE, HEALTH MAINTENANCE ORGANIZATIONS AND PREFERRED PROVIDER ORGANIZATIONS, AND BLUE CROSS.	32.2%	29.5%
UTILIZATION - THE INCREASED TENDENCY TO UTILIZE MORE HEALTH CARE, OR MORE EXPENSIVE HEALTH CARE	17.8%	16.3%
CATASTROPHIC CASES - ORGAN TRANSPLANTS, BURN CASES, BIRTH DEFECTS, PREMATURE BIRTHS AND COMPLICATIONS OF PREGNANCY, AIDS, HEAD TRAUMA CAUSED BY ACCIDENTS	7.2%	8.8%
TECHNOLOGICAL ADVANCES	6.7%	11.2%
MALPRACTICE	.6%	1.4%
TOTAL	100.0%	100.0%

ARE THERE ANY STRATEGIES WE CAN EMPLOY THAT WILL HELP REDUCE OR MINIMIZE THE EFFECT OF THESE FACTORS THAT ARE FORCING GROUP HEALTH INSURANCE PREMIUMS UPWARD? LET'S EXAMINE EACH ONE TO SEE.

MEDICAL INFLATION - THE ONLY WAY WE CAN AVOID THE EFFECTS OF MEDICAL INFLATION ON RATES IS TO ELIMINATE CLAIMS FROM BEING INCURRED IN THE FIRST PLACE. THE ONLY PROVEN MEANS OF ACCOMPLISHING THIS IS TO INCREASE DEDUCTIBLES AND CO-INSURANCE REQUIREMENTS IN ORDER TO SHIFT SOME OF THE BURDEN OF BENEFIT COST TO THOSE WHO UTILIZE THE PLAN. UNDER CURRENT MINIMUM STANDARDS WE HAVE LITTLE ROOM TO MANIPULATE THESE PLAN COMPONENTS. THUS, THERE IS VERY LITTLE WE CAN DO TO AVOID THE IMPACT OF INFLATION ON PREMIUMS.

COST SHIFTING - THERE IS NOTHING WE CAN DO TO CHANGE THE COURSE OF THE FEDERAL GOVERNMENT IN REDUCING ITS PAYMENT SCHEDULES TO HEALTH CARE PROVIDERS WHO TREAT MEDICARE AND MEDICAID RECIPIENTS. THIS SITUATION WILL WORSEN UNDER THE CURRENT BUSH ADMINISTRATION BUDGET PROPOSALS WHICH INCLUDE FURTHER REDUCTIONS IN BENEFIT PAYMENTS FOR MEDICARE AND MEDICAID PATIENTS. HOSPITALS AND PHYSICIANS RECEIVE 60% OF THEIR REVENUE THROUGH THE MEDICARE AND MEDICAID PROGRAMS. AS FURTHER CUTBACKS ARE IMPOSED, THESE PROVIDERS LOOK TO PRIVATE INSURANCE TO MAKEUP TO SHORTFALL. DISTRICTS LOCATED IN NON-METROPOLITAN AREAS ARE UNABLE TO TAKE ADVANTAGE OF SIGNIFICANT DISCOUNTS THROUGH DEVELOPING PREFERRED PROVIDER ORGANIZATIONS. THERE IS LITTLE COMPETITION AMONG PHYSICIANS AND HOSPITALS IN THESE COMMUNITIES, AND THERE CERTAINLY IN NO OVER ABUNDANCE OF HEALTH CARE RESOURCES. AT THE SAME TIME, PLAN PARTICIPANTS IN NEED OF ACUTE HEALTH CARE FREQUENTLY TRAVEL TO URBAN CENTERS WHICH FUNCTION AS REGIONAL PROVIDERS OF ACUTE CARE. BY DOING SO THEY WALK RIGHT INTO THE FULL IMPACT OF COST SHIFTING. IN SHORT, THE LARGER, MORE IMPACTIVE CLAIMS RESULT IN HIGHER CHARGES TO THE GROUP'S EXPERIENCE BECAUSE THE PROVIDERS ARE "SHIFTING" THE COST OF LOST REVENUE TO THESE PATIENTS. IN THESE LARGER COMMUNITIES, THE PROVIDERS ARE FORCED TO OFFER DISCOUNTS TO MANY EMPLOYERS IN ORDER TO COMPETE OF LOCAL PATIENTS. FINALLY, AS COSTS RISE, AND THE ABILITY OF LOWER PAID EMPLOYEES TO AFFORD DEPENDENT COVERAGE IS DIMINISHED, PROVIDERS FIND THEY MUST PROVIDE MORE CHARITY CARE. THE SIMPLY "MARK-UP" THE BILL FOR THOSE WHO HAVE THE ABILITY TO PAY BECAUSE OF THE EXISTENCE OF GROUP HEALTH INSURANCE. THERE IS LITTLE WE CAN DO TO AVOID THIS COST FACTOR.

UTILIZATION - WE HAVE OBSERVED, RECORDED, AND DOCUMENTED THE FACT THAT THERE IS A GENERAL INCREASED TENDENCY ON THE PART OF AMERICANS TO SEEJ HEALTH CARE MORE FREQUENTLY THAN IN THE PAST. THIS IS DUE IN PART TO THE FACT THAT EMPLOYERS HAVE NOT INCREASED DEDUCTIBLES AND CO-INSURANCE LEVELS IN RECENT YEARS SO THAT PLANS HAVE EVOLVED INTO "PRE-PAID HEALTH PLANS" NOT "CATASTROPHIC INSURANCE COVERAGES" AS THEY WERE ORIGINALLY DESIGNED. EMPLOYEES HAVE LITTLE FINANCIAL INVOLVEMENT IN THEIR HEALTH CARE CONSUMPTION PRACTICES. UNDER

CURRENT STATE MANDATED MINIMUM BENEFIT STANDARDS WE HAVE LITTLE LATITUDE TO AVERT THE IMPACT ON HEALTH INSURANCE PREMIUMS OF THIS FACTOR.

CATASTROPHIC CASES - WITH EVERY PASSING DAY WE ARE DEVELOPING NEW CURES, NEW TREATMENTS, AND NEW DIAGNOSTIC TECHNIQUES. IN THE PAST FEW YEARS WE HAVE SEEN REMARKABLE ADVANCES IN THE TREATMENT OF CANCER, HEART DISEASE, AND OTHER MAJOR ILLNESSES. MOREOVER, WE HAVE DEVELOPED THE TECHNOLOGY AND KNOWLEDGE TO ALLOW ORGAN TRANSPLANTS TO BECOME A COMMON PLACE TREATMENT FOR CERTAIN ILLNESSES. OUR ABILITY TO TREAT BURN VICTIMS AND HEAD TRAUMA VICTIMS HAS INCREASE. THROUGH DEVELOPMENTS IN NEO-NATAL INTENSIVE CARE PROCEDURES, WE ARE VERY SUCCESSFUL IN DEALING WITH COMPLICATED PREGNANCIES AND PREMATURE BIRTHS. IN ADDITION TO NEW TECHNOLOGY WE ARE NOW FACED WITH NEW DISEASES. AIDS IS A POTENTIALLY DISASTROUS DISEASE THAT WILL COST BILLIONS OF DOLLARS TO TREAT IN THE YEARS AHEAD. THE EXTENT OF THE SPREAD OF THIS VIRUS IS YET TO BE DETERMINED, BUT INSURERS ARE VERY CONCERNED. ALL OF THESE FACTORS PROVIDE THE UNDERLYING CAUSE IN THE UNPRECEDENTED RISE IN THE INCIDENCE OF CATASTROPHIC CLAIMS. THE REALLY DISTURBING ASPECT OF THIS FACTOR IS THAT THE ILLNESSES AND ACCIDENTS LISTED ABOVE OCCUR MOST FREQUENTLY IN THE YOUNGER ELEMENT OF OUR WORK FORCE. THIS SHOULD PROVIDE SOME CAUSE FOR CONCERN ON THE PART OF THE "WHAT'S THE PROBLEM?' GROUP OF DISTRICTS WHO OWE THEIR PRESENT GOOD FORTUNE TO A YOUTHFUL EMPLOYEE CENSUS. THESE FACTORS ALSO UNDERSCORE THE POTENTIAL TRAGEDY THAT WILL SURELY RESULT AS MORE AND MORE OF OUR LOWER PAID EMPLOYEES FIND DEPENDENT PREMIUMS TO BE UN-AFFORDABLE THUS LEAVING THEIR SPOUSES AND CHILDREN UNINSURED.

TECHNOLOGY - A CLOSE RELATIVE OF THE CATASTROPHIC CASES FACTOR JUST DISCUSSED IS THE INCREASED TECHNOLOGY FACTOR. THE COST OF STATE-OF-THE-ART EQUIPMENT AND PROCEDURES IS VERY HIGH, AND OBSOLESCENCE OCCURS RAPIDLY. MOREOVER, AS HOSPITALS COMPETE FOR PATIENTS, THEY TEND TO DUPLICATE THESE RESOURCES, OFTEN NEEDLESSLY AND INEFFICIENTLY. UNDER-UTILIZED TECHNOLOGY RESULTS IN EVEN HIGHER CHARGES TO THOSE WHO DO UTILIZE IT.

MALPRACTICE - DEFENSIVE MEDICINE IS A COSTLY METHOD OF PRACTICE. PHYSICIANS AND HOSPITALS ORDER EXCESSIVE TESTS AND DIAGNOSTIC PROCEDURES IN A EFFORT NOT TO BE OPEN TO A MALPRACTICE LAWSUIT. THE TORT LAWS IN TEXAS HAVE EXACERBATED THE PROBLEM. IN ADDITION THE COST OF MALPRACTICE INSURANCE CONTINUES TO RISE DRAMATICALLY IN RESPONSE TO HUGE JURY AWARDS. THOSE COSTS ARE PASSED ON TO THE PATIENT IN THE FORM OF HIGHER CHARGES FOR HEALTH CARE SERVICES.

IT IS APPARENT AFTER REFLECTING ON THESE GENERAL HEALTH CARE COST INCREASE FACTORS THAT ALL OF THEM ARE SUBSTANTIALLY BEYOND OUR CONTROL AS PLAN MANAGERS.

HEALTH CARE COST FACTORS MORE UNIQUE TO COMMUNITY COLLEGES

MINIMUM BENEFIT STANDARDS - COMMUNITY COLLEGES MUST PROVIDE THEIR EMPLOYEES, COBRA PARTICIPANTS, AND RETIREES BENEFITS BASED ON PRESCRIBED MINIMUM STANDARDS. THESE BENEFIT STANDARDS HAVE NOT BEEN SIGNIFICANTLY MODIFIED IN RESPONSE TO RISING HEALTH CARE COSTS OVER THE PAST FEW YEARS. THIS "FREEZE" IN BENEFIT LEVELS PLACES TREMENDOUS PRESSURE ON PREMIUMS. THE STATE REQUIRES THAT EACH DISTRICT PROVIDE A PLAN THAT PROVIDES FOR AN INDIVIDUAL CALENDAR YEAR OUT-OF-POCKET MAXIMUM OF $1,000. LET'S LOOK AT THE IMPACT ON PLAN FUNDING OVER A PERIOD OF FIVE YEARS.

ELIGIBLE CHARGES	$5,000	$5,750	$6,785	$8,210	$9,934
DEDUCTIBLE	200	200	200	200	200
ELIGIBLE AFTER DEDUCTIBLE	4,800	5,550	6,585	8,010	9,734
PAYABLE @ 80%	1,600	1,600	1,600	1,600	1,600
PAYABLE @ 100%	2,800	3,550	4,585	6,010	7,734
TOTAL PAYABLE	4,400	5,150	6,185	7,610	9,334
PAID CLAIMS INCREASE IN %	0%	17%	20%	23%	23%
INCREASE OVER 1986	0%	17%	41%	73%	112%
ACTUAL MEDICAL INFLATION FACTOR		15%	16%	21%	21%

IS THERE ANY WONDER WHY COMMUNITY COLLEGES HAVE EXPERIENCED GREATER PREMIUM INCREASES ON AVERAGE THAN THEIR PRIVATE SECTOR COUNTERPARTS WHO HAVE THE FLEXIBILITY TO ADJUST BENEFITS IN RESPONSE TO RISING HEALTH CARE COSTS? CAN YOU UNDERSTAND WHY THE NUMBER OF INSURERS WILLING TO UNDERWRITE COMMUNITY COLLEGES IS DIMINISHING RAPIDLY? AND CAN YOU SEE A PERCEPTION PROBLEM ON THE PART EMPLOYEES WHO WOULD BELIEVE THAT THERE BENEFIT PLAN HAD REMAINED UNCHANGED DURING THE ABOVE FIVE YEAR PERIOD, WHEN IN FACT, THE PLAN WAS REQUIRED TO INCREASE IS FUNDING RESPONSIBILITY BY 112% OVER THE 1986 LEVEL? IN SHORT, THE RIGIDITY OF THE MINIMUM STANDARDS IS CREATING AN IMPOSSIBLE SITUATION RELATIVE TO MAINTAINING AFFORDABLE GROUP HEALTH INSURANCE COVERAGE.

EACH SESSION OF THE LEGISLATURE BRINGS ADDITIONAL STATE MANDATED BENEFITS. THIS PAST SESSION COVERAGE FOR SUBSTANCE ABUSE AND TMJ SURGERY WERE ADDED TO THE LIST. THE COST OF THESE NEW MANDATED BENEFITS IS ESTIMATED TO BE 10%. THESE MANDATED BENEFITS HAVE HISTORICALLY BE AUTOMATICALLY INCLUDED IN THE STATE'S MINIMUM STANDARDS.

ADVERSE RISK SELECTION – AS PREMIUMS ESCALATE IN RESPONSE TO A MIX OF INFLATION AND INFLEXIBLE PLAN DESIGN, THE COST OF DEPENDENT COVERAGE WILL ESCALATE BEYOND THE LEVEL OF AFFORDABILITY FOR MOST EMPLOYEES WHO DESIRE TO INSURE THEIR DEPENDENTS. EVEN WITH THE STATE'S NEW DIRECTION OF PROVIDING ADDITIONAL FUNDING FOR EMPLOYEES WISHING TO COVER DEPENDENTS, PREMIUM INCREASES WILL OUTSTRIP STATE FUNDING CAPACITY, LEAVING EMPLOYEES WITH THE CHOICE OF PAYING EXORBITANT RATES FOR DEPENDENT COVERAGE, SEEKING LOWER COST ALTERNATIVES TO GROUP BENEFITS, OR LEAVING THEIR DEPENDENTS UN-INSURED. THE FINAL OUTCOME OF THIS SCENARIO IS DISASTROUS TO A GROUP HEALTH INSURANCE PLAN.

THOSE EMPLOYEES WHO ARE UNWILLING TO PAY REQUIRED DEPENDENT PREMIUMS ARE MOST LIKELY THE BEST RISK ELEMENT WITHIN THE GROUP. THEY ARE WILLING TO GAMBLE ON GOOD HEALTH BY GOING UN-INSURED. THOSE EMPLOYEES WHO OBTAIN DEPENDENT COVERAGE OUTSIDE THE GROUP PLAN ARE OBVIOUSLY A RELATIVELY HEALTHY CLASS IN THAT INDIVIDUAL COVERAGES ARE MEDICALLY UNDERWRITTEN, AGE RATED, AND CONTAIN MUCH MORE RESTRICTIVE POLICY PROVISIONS AND LESSER BENEFITS THAN THOSE OFFERED BY THE GROUP PLAN. IF THE GROUP PLAN IS LEFT ONLY WITH THE POOREST RISK ELEMENT IN TERMS OF COVERED DEPENDENTS, OBVIOUSLY PREMIUMS WILL HAVE TO ESCALATE FOR THE REMAINING DEPENDENTS TO OFFSET THE LOSS OF "HEALTHY" PREMIUM. THE EXODUS OF HEALTHY PREMIUM FROM THE GROUP DOES NOT CARRY WITH IT ANY SIGNIFICANT CLAIM LIABILITY REDUCTION. IN SHORT THE GROUP IS LEFT WITH A SIMILAR CLAIMS LIABILITY TO BE FUNDED BY FEWER DEPENDENT UNITS. AS PREMIUMS ARE ADJUSTED UPWARD TO CORRECT THIS SITUATION, THE NEXT LEVEL OF "HEALTHIER" DEPENDENTS DEPARTS, AND SO IT GOES UNTIL ONLY THE TOTALLY UNINSURABLE DEPENDENT RISK ELEMENT REMAINS.

AN AGING POPULATION–THE RATE OF TURN-OVER AMONG ADMINISTRATIVE AND PROFESSIONAL STAFF AMONG COMMUNITY COLLEGES IS EXTREMELY LOW. AS A RESULT, OVER TIME, INSTITUTIONS WILL DEVELOP AN EVER EXPANDING CENSUS OF RETIREES, MANY WITHOUT MEDICARE COVERAGE. THESE INDIVIDUALS, AND THEIR DEPENDENTS MUST BE PROVIDED MINIMUM STANDARD COVERAGE FOR LIFE. NO PROVISION FOR FUNDING THE ACCRUING RETIREE HEALTH CARE LIABILITY HAS EVER BEEN MADE BY COMMUNITY COLLEGES IN THE PAST. UNDER NEWLY DEVELOPED GUIDELINES FROM THE FISCAL ACCOUNTING STANDARDS BOARD (FASB), PRIVATE SECTOR EMPLOYERS WILL BE REQUIRED TO REFLECT ACCRUING RETIREE HEALTH INSURANCE LIABILITY ON THEIR FINANCIAL STATEMENTS JUST AS THEY CURRENTLY DO FOR PENSION PLANS. IF THESE STANDARDS WERE TO BE APPLIED TO COMMUNITY COLLEGES, THE SERIOUSNESS OF THIS DEVELOPING PROBLEM WOULD BE APPARENT TO EVERY BENEFIT MANAGER AND FINANCIAL OFFICER. AS IT IS WE ARE CHOOSING TO FUND RETIREE HEALTH CARE COSTS ON A "PAY AS WE GO" BASIS. THIS APPROACH WILL INSURE A TREMENDOUS ESCALATION IN HEALTH INSURANCE PREMIUMS OVER THE NEXT DECADE AS THE "BABY BOOMERS" BEGIN TO REACH RETIREMENT AGE.

THE NATIONAL CENTER FOR HEALTH STATISTICS RECENTLY RELEASED ITS 1987 STATISTICS ON HOSPITAL UTILIZATION BY AGE GROUP:

	ADMISSIONS PER 1,000
UNDER AGE 15	51.3
AGE 15 TO 45	115.1
AGE 45 TO 65	156.9
AGE 65 AND OVER	350.6
FOR ALL AGES	138.2

OBVIOUSLY, AS WE AGE WE HAVE A GREATER AND MORE FREQUENT NEED FOR HEALTH CARE. AS THE AGE MIX OF OUR CENSUS INCREASES OVER THE YEARS AHEAD, OUR PREMIUMS WILL SURELY FEEL THE IMPACT. SHORTLY AFTER THE BEGINNING OF THE NEXT CENTURY, PERHAPS WITHIN THE NEXT 15 YEARS, THE WORK FORCE WILL BE COMPRISED OF 50% OF ITS WORKERS BEING OVER THE AGE OF 65. BY THE MIDDLE OF THE NEXT CENTURY, TWO-THIRDS OF THE WORK FORCE WILL BE OVER AGE 65. AS TECHNOLOGICAL ADVANCES ARE MADE IN MEDICINE, LIFE EXPECTANCY INCREASES. MANY FEEL WE WILL EXCEED THESE TIME TABLES AS ADVANCES ARE MADE IN PREVENTIVE MEDICINE.

HEALTH MAINTENANCE ORGANIZATIONS

THESE ALTERNATE DELIVERY SYSTEMS HAVE REAPED HAVOC WITH THE GROUP HEALTH INSURANCE PLANS OF MANY OF THE COMMUNITY COLLEGES IN THE STATE. EVEN WITH RECENT CHANGES IN THE FEDERAL HMO ACT, MANY DISTRICTS HAVE NOT TAKEN ADVANTAGE OF THE POWER GIVEN THEM IN THESE REVISIONS IN BRINGING THE HMO'S UNDER CONTROL WITHIN THEIR GROUP INSURANCE PLAN. HMO'S TEND TO ATTRACT THE YOUNGER, HEALTHIER RISK AWAY FROM THE TRADITIONAL INDEMNITY PLAN. HMO'S ENGAGE IN SHADOW PRICING SO AS TO APPEAL TO THE HEALTHIER RISK ELEMENT WHO ARE MORE INTERESTED IN LOWER RATES. IN ADDITION, HEALTHIER EMPLOYEES TEND TO HAVE NO ESTABLISHED PHYSICIAN RELATIONSHIP THAT MIGHT OTHERWISE BE DISRUPTED BY HMO PARTICIPATION. FINALLY, RETIREES TEND TO LIVE OUTSIDE THE HMO SERVICE AREA AND MUST JOIN THE INDEMNITY PLAN. THE RESULT OF THIS FORM OF ADVERSE RISK SELECTION IS AN ESCALATING PRICE DIFFERENTIAL IN FAVOR OF THE HMO. ULTIMATELY, PARTICIPATION IN THE INDEMNITY PLAN MAY DETERIORATE TO THE POINT THAT NO INDEMNITY CARRIER WILL UNDERWRITE THAT SEGMENT OF THE RISK.

COMMUNITY COLLEGES, AS PUBLIC EMPLOYERS, HAVE TENDED NOT TO RESIST HMO PENETRATION IN SPITE OF THE DEVASTATING IMPACT IT HAS ON THE FISCAL VIABILITY OF THE INDEMNITY PLAN.

SUMMARY

WITH ALL OF THESE FACTORS IN OPERATION, EXERTING THEIR INFLUENCE ON THE COST OF HEALTH INSURANCE, IT IS APPARENT THAT NO COMMUNITY COLLEGE DISTRICT CAN "GO IT ALONE" IN THE FUTURE. EXTREME RATE VOLATILITY IS THE ORDER OF THE DAY. IF YOU CURRENTLY BELONG TO THE "WHAT'S THE PROBLEM" GROUP, IT IS THE RESULT OF VERY GOOD FORTUNE RATHER THAN GOOD MANAGEMENT. THE PROBLEMS THAT HAVE ALREADY VISITED MOST OF YOUR PEERS WILL FIND THEIR WAY INTO YOUR INSTITUTION VERY SHORTLY. IT IS NOT A QUESTION OF "IF", JUST A QUESTION OF "WHEN". ONE COMMUNITY COLLEGE DISTRICT JUMPED FROM THE "WHAT'S THE PROBLEM" GROUP DIRECTLY TO THE "HELP ME NOW!" GROUP AS THE RESULT OF A CAR WRECK INVOLVING ONE OF ITS EMPLOYEES. ANOTHER INSTITUTION HAD THE SAME EXPERIENCE AS THE RESULT OF A DEPENDENT CHILD WHO WAS A HEMOPHILIAC. THE SMALLER THE INSTITUTION, THE MORE VULNERABLE IT IS TO RATE VOLATILITY DUE TO A DRAMATIC CHANGE IN BENEFIT UTILIZATION. IN THIS DAY AND AGE, A DISTRICT'S HEALTH INSURANCE RATES CAN MORE THAN DOUBLE IN A SINGLE YEAR. ONLY BY BANDING TOGETHER CAN COMMUNITY COLLEGE DISTRICTS SURVIVE THE CURRENT CRISIS IN HEALTH CARE FINANCING.

THE POSITIVE EFFECTS OF THE CONSORTIUM

LOWER ADMINISTRATIVE COSTS - BY PURCHASING CLAIMS ADMINISTRATION AND OTHER ADMINISTRATIVE SERVICES ON A STATE-WIDE BASIS, EVERY DISTRICT WILL FIND LESS OF ITS PREMIUM DOLLARS GOING TO FUND THESE COSTS. THOSE INSTITUTIONS THAT UTILIZE THE SERVICES OF A LOCAL AGENT WILL SAVE THE COST OF COMMISSIONS. THIS LEAVES MORE DOLLARS AVAILABLE TO FUND CLAIMS.

LOWER POOLING CHARGES - BECAUSE A STATE-WIDE CONSORTIUM WILL PRODUCE A MUCH BROADER SPREAD OF RISK, HIGHER POOLING POINTS WILL BE ACCEPTABLE, THUS REDUCING THE PREMIUM COMPONENT FOR THIS COVERAGE.

RATE STABILITY - A BROADER SPREAD OF RISK WILL ALSO PROMOTE GREATER RATE STABILITY. THE CATASTROPHIC CLAIM WILL BE LESS IMPACTIVE AS ITS IMPACT IS DIFFUSED BY THE SIZE OF THE CONSORTIUM.

REDUCED STAFF COSTS - DISTRICT PERSONNEL WILL NO LONGER HAVE TO DEAL WITH INSURANCE AGENTS, DEVELOPING BID SPECIFICATIONS, ANALYZING BIDS, NEGOTIATING WITH CARRIERS, STORING HISTORICAL CLAIMS AND PREMIUM DATA, AND REPORTING PLAN PROVISIONS AND PERFORMANCE TO THE FEDERAL GOVERNMENT AS REQUIRED BY ERISA AND SECTION 89 IRC.

INCREASED CARRIER INTEREST – THE DIMENSIONS OF THE CONSORTIUM WILL APPEAL TO INSURANCE CARRIERS. AS THE NUMBER OF CARRIERS WILLING TO UNDERWRITE GROUP HEALTH INSURANCE DECREASES, THE CONSORTIUM WILL CONTINUE TO ATTRACT QUALITY CARRIERS.

POLITICAL INFLUENCE – A UNIFIED COMMUNITY COLLEGE CONSORTIUM WILL BE IN A POSITION TO DEVELOP A LEGISLATIVE AGENDA THAT WILL FAVOR SOUND BENEFIT PLAN MANAGEMENT AND FINANCING. IN ADDITION, THE CONSORTIUM CAN COMMAND GREATER ATTENTION AND INFLUENCE WITH THE COORDINATING BOARD IN AN EFFORT TO REVISE THE BASIC MINIMUM STANDARDS, AND TO INFLUENCE POLICY DECISIONS TO BENEFIT COMMUNITY COLLEGES.

GREATER AUTONOMY AND SELF-DETERMINATION – A FAILURE TO ACT ON THIS PROJECT AT THIS TIME WILL LIKELY RESULT IN ACTION ON THE PART OF THE LEGISLATURE AND THE COORDINATING BOARD THAT WILL RESULT IN THE TOTAL LOSS OF AUTONOMY AND SELF-DETERMINATION ON THE PART OF ALL COMMUNITY COLLEGES. A RECENTLY PUBLISHED STUDY BY A CONSULTING FIRM COMMISSIONED BY THE ADMINISTRATIVE COUNCIL RECOMMENDED THAT UNIVERSITIES BE ALLOWED TO MANAGE THEIR EMPLOYEE BENEFIT PLANS WITHOUT FURTHER CONTROLS BEING IMPOSED BY THE STATE. HOWEVER, THE REPORT CONCENTRATED ON ITS RECOMMENDATION THAT COMMUNITY COLLEGES BE MANDATED INTO A STATE-WIDE PLAN ADMINISTERED BY THE ASSOCIATION.

IN A RELATED LEGISLATIVE ACTION, PART OF THE SUNSET LEGISLATION PROVIDED FOR THE ADMINISTRATIVE COUNCIL TO DEVELOP A STANDARDIZED SET OF BENEFIT SPECIFICATION TO BE USED BY COMMUNITY COLLEGES WITH FEWER THAN 500 EMPLOYEES AND BY LARGER INSTITUTIONS THAT ARE FOUND TO BE OUT OF COMPLIANCE WITH MINIMUM BENEFIT STANDARDS. BY REQUIRING SMALLER COMMUNITY COLLEGES TO CONFORM TO A STANDARD PLAN DESIGN, IT BECOMES POSSIBLE TO DEVELOP A HISTORICAL DATA BASE TO FACILITATE THE FINAL CONSOLIDATION OF COMMUNITY COLLEGES INTO A SINGLE STATE ADMINISTERED PLAN.

ONE MIGHT ASK IF STATE ADMINISTRATION AND CONTROL WOULD BE A BAD THING. I WOULD RESPOND THAT THIS APPROACH WOULD LIKELY RESULT IN THE STATE HAVING AUTHORITY TO MANDATE PLAN DESIGN, CARRIER SELECTION, AND PRICING. AT THE SAME TIME, STATE FUNDING MIGHT BE INADEQUATE TO FUND THE REQUIRED PLAN, LEAVING THE DISTRICTS TO PROVIDE FUNDING FROM LOCAL REVENUE. I BELIEVE THAT THE COMMUNITY COLLEGE DISTRICTS CAN DO A BETTER JOB OF SELF MANAGEMENT AND CONTROL OF THEIR EMPLOYEE BENEFITS PLAN. PRIVATE INITIATIVE GENERALLY HAS PROVEN TO BE MORE EFFICIENT AND EFFECTIVE THAN MANAGEMENT AND CONTROL THROUGH STATE BUREAUCRACY.

COMMON DATA BASE - THE FORMATION OF A STATE-WIDE CONSORTIUM MANAGED BY A COMMON BENEFIT CONSULTING FIRM OFFERS THE OPPORTUNITY TO ESTABLISH A HISTORICAL BENEFIT UTILIZATION DATA BASE THAT WILL BE VALUABLE IN PETITIONING THE LEGISLATURE AND COORDINATING BOARD FOR CHANGES IN THE MINIMUM STANDARDS.

THE STRUCTURE

BOARD OF TRUSTEES - A BOARD WOULD BE ELECTED TO OVERSEE THE MANAGEMENT OF THE CONSORTIUM PLAN. WORKING WITH THE BENEFIT CONSULTANT, LEGAL STAFF, AND AN INDEPENDENT AUDIT FIRM THE BOARD WOULD MEET PERIODICALLY TO REVIEW THE PERFORMANCE OF THE PLAN.

REGIONAL ZONES - BASED ON THE REGIONAL HEALTH CARE DELIVERY SYSTEMS THAT HAVE DEVELOPED ACROSS THE STATE, REGIONAL ZONES WOULD BE DEVELOPED TO FACILITATE NEGOTIATIONS WITH AREA PROVIDERS TO ESTABLISH LOCAL PREFERRED PROVIDER ORGANIZATION AND HEALTH MAINTENANCE ORGANIZATION NETWORKS WITH RECIPROCITY WITH THE OTHER REGIONAL ZONES. THIS REGIONAL FLEXIBILITY WILL SERVE TO REDUCE OVERALL PLAN COST THROUGH NEGOTIATED DISCOUNTS.

LARGER DISTRICTS - WHILE THE LARGER DISTRICTS, THOSE WITH 2,000 OR MORE EMPLOYEES, WILL PARTICIPATE IN THE COST SAVINGS THAT WILL RESULT FROM PURCHASING ADMINISTRATIVE AND POOLING COSTS ON A STATE-WIDE BASIS, THESE INSTITUTIONS WILL REMAIN OUTSIDE THE POOL COMPRISED OF SMALLER DISTRICTS. THEY WILL BE ABLE TO DEVELOP MODIFIED PLAN DESIGNS IF THEY CHOOSE TO DO SO. THEIR CLAIMS EXPERIENCE WILL NOT IMPACT RATES FOR THE SMALLER DISTRICTS.

SMALLER DISTRICT POOL - THOSE DISTRICTS WITH FEWER THAN 2,000 EMPLOYEES WILL FORM A SINGLE COMBINED RISK POOL IN ORDER TO ACHIEVE COST SAVINGS AND PRICE STABILITY.

OTHER SERVICES - WHILE THE INITIAL EMPHASIS OF THE CONSORTIUM WILL BE FOCUSED ON GROUP HEALTH AND BASIC TERM LIFE (THE MINIMUM STANDARDS), THE CONSULTANT WILL BE AVAILABLE TO ALL DISTRICTS IN NEED OF ADDITIONAL CONSULTING SERVICES. DISTRICTS WILL RECEIVE THESE ADDITIONAL CONSULTING SERVICES AT A DISCOUNTED HOURLY BILLING RATE.

COURSE OF ACTION AND TIME TABLE FOR IMPLEMENTATION

COMMITMENT - WE NEED A FIRM COMMITMENT OF PARTICIPATION. WE ANTICIPATE BEING ABLE TO DEVELOP PRICING FOR THE CONSORTIUM WITHIN A RANGE OF 110% OF THE CURRENT LEVEL OF STATE FUNDING. YOUR COMMITMENT AT THIS POINT IS TO PARTICIPATE IN THE STATE-WIDE CONSORTIUM PROVIDED THE PRICING FALLS WITHIN THIS RANGE OF TOLERANCE.

TO ASSIST YOU IN OBTAINING THIS COMMITMENT, WE WILL PROVIDE YOU WITH A VIDEO TAPE OF THIS PRESENTATION FOR YOUR USE IN INTRODUCING THE CONCEPT TO YOUR STAFF, YOUR BOARD, AND YOUR EMPLOYEE BENEFITS COMMITTEE. IN ADDITION, WE WILL HOLD REGIONAL WORKSHOPS IN THE NEXT FEW WEEKS TO WHICH YOU MAY SEND ANY DISTRICT REPRESENTATIVES THAT YOU FEEL WOULD BENEFIT FROM A PERSONAL ORIENTATION TO THIS CONCEPT. WE WILL ALSO BE AVAILABLE TO ATTEND BOARD MEETINGS AT YOUR REQUEST.

DATA GATHERING - WE HAVE DEVELOPED A DATA GATHERING FORMAT FOR YOUR USE IN REPORTING THE DATA ABOUT YOUR CURRENT AND PREVIOUS BENEFIT PLANS THAT WILL BE NECESSARY IN OBTAINING PROPOSALS.
PROPOSAL SPECIFICATIONS WILL BE DEVELOPED AND SUBMITTED TO INTERESTED ELIGIBLE BIDDERS. RESPONSES WILL BE RECEIVED AND ANALYZED, AND RECOMMENDATIONS WILL BE PROVIDED TO THE BOARD FOR CARRIER SELECTION.

LEGAL MATTERS - A LAW FIRM WILL BE RETAINED TO DEVELOP THE NECESSARY DOCUMENTATION AND FILINGS TO ESTABLISH THE PLAN. THEY WILL BE RESPONSIBLE FOR ALL LEGAL ASPECTS OF PLAN MAINTENANCE.

ELECTION OF THE BOARD - THE DISTRICTS WILL SELECT A BOARD TO OVERSEE THE MANAGEMENT OF THE PLAN. THE BOARD WILL BE CHARGED WITH SELECTING AN AUDIT FIRM, ESTABLISHING BANKING ARRANGEMENTS, AND CREATING THE BY-LAWS GOVERNING THE OPERATION OF THE PLAN.

TARGET DATE FOR INCEPTION - WITH THE COOPERATION OF THE DISTRICTS IN PROMPTLY RETURNING THE COMPLETED DATA GATHERING FORMS, IT WILL BE POSSIBLE TO INITIATE THE PLAN EFFECTIVE JANUARY 1, 1990. THE INITIAL RATE GUARANTEE WILL BE FOR NINE MONTHS. THE RENEWAL WILL BE EFFECTIVE ON SEPTEMBER 1, 1990 AND WILL CONTINUE ON A TWELVE MONTH BASIS THEREAFTER.

LATE ENTRANTS - ANY INSTITUTION NOT ELECTING TO JOIN THE CONSORTIUM INITIALLY WILL BE ELIGIBLE TO JOIN AT A LATER DATE SUBJECT TO THE APPROVAL OF THE BOARD. IT SHOULD BE NOTED THAT THE BOARD WILL BE UNWILLING TO ACCOMMODATE THOSE INSTITUTIONS WHO DELAY JOINING THE CONSORTIUM UNTIL THEIR PLAN EXPERIENCES A DRASTIC RATE INCREASE. THERE WILL BE A FEW DISTRICTS THAT CANNOT END THEIR CURRENT ARRANGEMENT PRIOR TO THEIR NEXT RENEWAL DATE. THESE DISTRICTS WILL BE GUARANTEED THE RIGHT TO JOIN THE CONSORTIUM AT THEIR NEXT RENEWAL PROVIDED THEY AGREE TO DO SO NOW. THESE GROUPS MIGHT INCLUDE THOSE WHO HAVE SIGNED IRREVOCABLE INTER-LOCAL AGREEMENTS THROUGH THE TSSF-TASB PLAN, OR WHO ARE CURRENTLY INVOLVED IN A SELF-INSURED ARRANGEMENT WITH STOP-LOSS COVERAGE THAT DOES NOT ALLOW FOR EARLY CANCELLATION. THE PLAN'S BENEFIT CONSULTANT WILL BE WILLING TO REVIEW ANY DISTRICT'S CURRENT CIRCUMSTANCES AND CONTRACTUAL PROVISION TO DETERMINE IF JOINING THE CONSORTIUM IN JANUARY 1990 IS FEASIBLE.

CONCLUSION

IF YOU WILL ALLOW THE USE OF ONE MORE METAPHOR, I WOULD LIKE TO INVOKE TO IMAGE OF EBONEEZER SCROOGE. AS YOU PONDER YOUR DISTRICT'S SITUATION AND MAKE YOUR DECISION, I WOULD ARRANGE FOR YOU TO SPEND SOME TIME WITH THE GHOST OF GROUP HEALTH INSURANCE RENEWALS PAST, AND PRESENT. FINALLY, I WOULD SEND TO YOU THE GHOST OF GROUP INSURANCE RENEWAL FUTURE. PLEASE BELIEVE ME WHEN I TELL YOU THAT WITHOUT THE CONSORTIUM YOUR VISIT TO GROUP INSURANCE RENEWAL FUTURE WILL SEEM LIKE A NIGHTMARE. I'VE TRIED TO GIVE YOU A FACTUAL VISION OF THE PRESENT CIRCUMSTANCES SURROUNDING YOUR EMPLOYEE BENEFIT PROGRAM, AND IN DOING SO ALLOW YOU TO SEE THE DIRECT INWHICH WE ARE HEADING. HOPEFULLY THIS GLIMPSE OF THE FUTURE WILL CAUSE YOU TO TAKE THE ACTION NECESSARY TO BECOME INVOLVED IN THIS VOLUNTARY EFFORT. WE HAVE AN OPPORTUNITY TO DEMONSTRATE TO THE STATE THAT WE ARE WILLING AND ABLE TO MANAGE OUR OWN AFFAIRS. IN DOING SO WE WILL REMOVE THE MOTIVATION FOR THEM TO MANAGE OUR AFFAIRS FOR US.

ARE THERE ANY QUESTIONS?

"HELP ME NOW !!!!!!!"

"WE'RE OKAY FOR NOW...BUT"

"WHAT'S THE PROBLEM ?"

HEWITT ASSOCIATES STUDY OF

GENERAL FACTORS IMPACTING HEALTH CARE COSTS - 1989

	1988	1989
MEDICAL INFLATION	35.5%	32.8%
COST SHIFTING	32.2%	29.5%
INCREASE UTILIZATION	17.8%	16.3%
CATASTROPHIC CASES	7.2%	8.8%
TECHNOLOGICAL ADVANCES	6.7%	11.2%
MALPRACTICE	.6%	1.4%
TOTAL	100.0%	100.0%

HEALTH CARE COST FACTORS MORE UNIQUE TO COMMUNITY COLLEGES

* MINIMUM BENEFIT STANDARDS HAVE NOT BEEN ADJUSTED FOR INFLATION.

	1986	1987	1988	1989	1990
ELIGIBLE CHARGES	$5,000	$5,750	$6,785	$8,210	$9,943
DEDUCTIBLE	200	200	200	200	200
ELIGIBLE AFTER DEDUCTIBLE	4,800	5,550	6,585	8,010	9,734
PAYABLE @ 80%	1,600	1,600	1,600	1,600	1,600
PAYABLE @ 100%	2,800	3,550	4,585	6,010	7,734
TOTAL PAYABLE	4,400	5,150	6,185	7,610	9,334
PAID CLAIMS INCREASE IN PERCENTAGE		17%	20%	23%	23%
INCREASE OVER 1986		17%	41%	73%	112%
ACTUAL MEDICAL INFLATION FACTOR		15%	18%	21%	21%

HEALTH CARE COST FACTORS MORE UNIQUE TO COMMUNITY COLLEGES

* **MINIMUM BENEFIT STANDARDS HAVE NOT BEEN ADJUSTED FOR INFLATION**
    * CALENDAR YEAR DEDUCTIBLES
    * OUT-OF-POCKET MAXIMUMS
* ADDITIONAL STATE MANDATED BENEFITS
    * SUBSTANCE ABUSE
    * TMJ
* ADVERSE RISK SELECTION
    * DEPENDENT COVERAGE
* AGING CENSUS
    * LOW TURN OVER AMONG PROFESSIONAL STAFF
    * EARLY RETIREMENT
    * "PAY AS WE GO"
* HEALTH MAINTENANCE ORGANIZATIONS
    * ATTRACT YOUNGER, HEALTHIER RISK ELEMENT
    * ATTRACT DEPENDENT COVERAGE

THE NATIONAL CENTER FOR HEALTH STATISTICS

1987 STUDY ON HOSPITAL UTILIZATION BY AGE GROUP

	ADMISSIONS PER 1,000
UNDER AGE 15	51.3
AGE 15 TO 45	115.1
AGE 45 TO 65	156.9
AGE 65 AND OVER	350.6
FOR ALL AGES	138.2

THE POSITIVE EFFECTS OF THE CONSORTIUM

* LOWER ADMINISTRATIVE COSTS
* LOWER POOLING CHARGES
* LONG TERM RATE STABILITY
* REDUCED STAFF COSTS
* INCREASED CARRIER INTEREST
* POLITICAL INFLUENCE
* GREATER AUTONOMY AND SELF-DETERMINATION
* COMMON DATA BASE - CENTRALIZED SERVICE

THE STRUCTURE OF THE CONSORTIUM

* THE BOARD OF TRUSTEES
    * BENEFIT CONSULTANT
    * LEGAL ADVISOR
    * AUDITOR
* REGIONAL ZONES
    * BASED ON REGIONAL HEALTH CARE DELIVERY SYSTEMS
    * HMO'S AND PPO'S
* LARGER DISTRICTS
    * 2,000 OR MORE EMPLOYEES
    * NOT POOLED WITH SMALLER DISTRICTS
    * PURCHASE ADMINISTRATION AND POOLING
* SMALLER DISTRICTS
    * LESS THAN 2,000 EMPLOYEES
    * STATE WIDE COMBINED POOL
* OTHER SERVICES
    * OTHER BENEFIT CONSULTING NEEDS TO BE PROVIDED AT A REDUCED RATE

COURSE OF ACTION AND TIME TABLE FOR IMPLEMENTATION

* COMMITMENT
    * PRICING WITHIN 110% OF CURRENT STATE FUNDING
    * VIDEO COPY OF PRESENTATION
    * REGIONAL WORKSHOPS
    * CONSULTANT AVAILABLE FOR BOARD OF TRUSTEES MEETINGS
* DATA GATHERING
    * DISTRICTS PROVIDE CURRENT AND HISTORICAL DATA UTILIZING THE FORMATS PROVIDED
    * SPECIFICATIONS DEVELOPED AND SUBMITTED TO INTEREST PROPOSERS
    * ANALYSIS AND CONSULTANT'S RECOMMENDATIONS PROVIDED TO THE CONSORTIUM BOARD OF TRUSTEES
* LEGAL MATTERS
    * ESTABLISH PLAN AND ORGANIZATION
* ELECTION OF GOVERNING BOARD
    * DEVELOP BY-LAWS
    * ESTABLISH BANKING AND AUDIT PROCEDURES
* TARGET DATE FOR INCEPTION
    * JANUARY 1, 1990 IS TARGETED EFFECTIVE DATE
    * WILL TRANSITION TO A SEPTEMBER 1 PLAN ANNIVERSARY
* LATE ENTRANTS
    * WILL REQUIRE BOARD APPROVAL
    * SPECIAL SITUATIONS

HEWITT ASSOCIATES STUDY OF

GENERAL FACTORS IMPACTING HEALTH CARE COSTS - 1989

	1988	1989
MEDICAL INFLATION	35.5%	32.8%
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MALPRACTICE	.6%	1.4%
TOTAL	100.0%	100.0%

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March 29, 1991